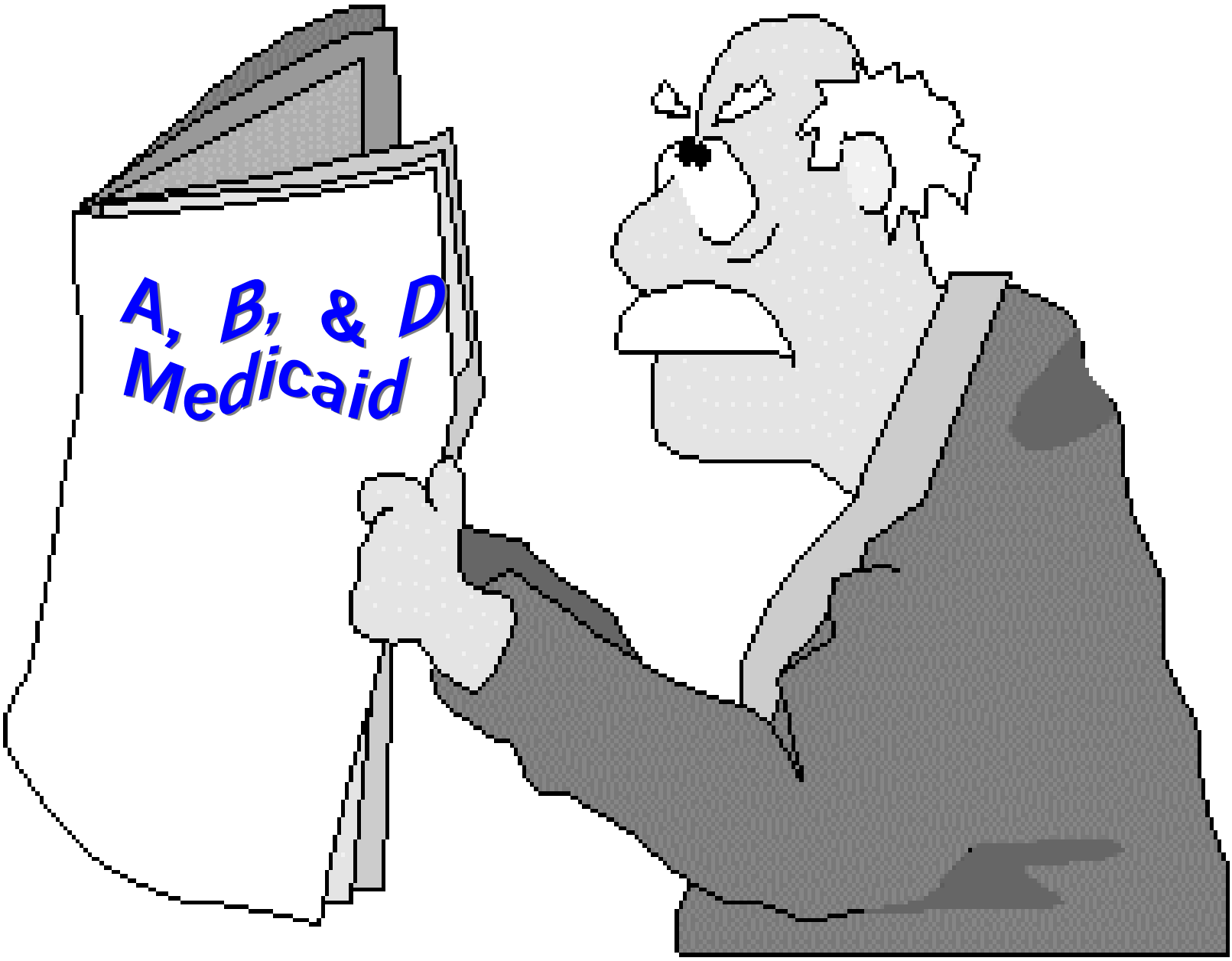
June 05



Department of Health
Bureau of Eligibility Services

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DEFINITIONS

BMS: Basic Maintenance Standard. The amount of income that is protected in determining the spenddown amount. Countable income over the BMS must be paid as a spenddown before there is Medicaid eligibility.

BUY - IN: Payment of the Part B Medicare Premium by Medicaid for Medicaid recipients. QMB, SLMB, and QI-1 recipients are also eligible for the Buy-In.

BUY- OUT: The Buy-Out is a federal law requiring the state to purchase available group health insurance for an individual who is eligible for Medicaid when it is cost effective.

COUNTABLE INCOME: The income left after all allowable deductions, disregards, etc. are deducted from the gross income. Countable income is different for different programs.

DEEMING: Determining how much of a person's income and assets should count when determining eligibility for Medicaid. The countable amount is determined only after taking the person's own needs AND the needs of other household members into account.

****Deeming Rule: Spouse for Spouse and Parent for Child.****

MEDICARE: Health insurance coverage administered through Social Security.

Medicare Part A- Hospital Coverage- usually free to those that are eligible.

Medicare Part B- Doctor Coverage-has a premium which is deducted from the recipient's Social Security checks.

PMV: Presumed Maximum Value. This is the policy which places value on food and shelter given to an A, B, or D recipient. It is also known as 'unearned income in kind'.

POVERTY LEVEL MEDICAL: A program which compares income to federal poverty limits and doesn't allow a spenddown. The poverty limit for AM or DM is income equal to or below 100% of poverty. *(Individuals who only qualify for BM **are not** eligible for the poverty level program.)*

SPENDDOWN: Spenddown is the difference between a person's countable income and the allowable program income limit. It is the amount of countable income which exceeds the BMS that an individual must pay (using **Cash** or **Medical Expenses**) in order to meet the income criteria for medical assistance.

FACTORS OF ELIGIBILITY

- **Application** - An application for Medicaid which has been signed and date stamped is the first factor of eligibility.

- **Residency** - There are 3 residency issues for eligibility:
  - ✦US Citizen or Qualified Alien
  - ✦Utah Resident
  - ✦Household or Institution (see page 6)

- **Social Security Number** - The applicant must give a correct social security number for each member applying for benefits or provide proof that they have applied for a number unless they are requesting Emergency Medicaid only.

- **Third Party Liability** (TPL) - The Form 19 must be completed. This form gathers information regarding other possible sources of payment for medical services. If the adult does not cooperate with this requirement, they can be sanctioned from medical benefits. Children are never sanctioned from medical benefits. Reporting changes in TPL is also a part of cooperation. Form 19 is now part of the application.

- **Medicaid Orientation** - The recipient must choose an Health Plan or Primary Care Provider (PCP) depending upon where they live. Instructions on how to use the Medicaid card and their benefits are also part of the orientation.

- **Duty of Support** - A recipient must cooperate with Duty of Support requirements by completing the packet on any absent parent. If the adult household member does not cooperate, they can be sanctioned from Medicaid benefits. Children are not sanctioned.

- **Program Type** - A person must be aged (65+) or determined blind or disabled by Social Security or Medical Review Board to be eligible for the programs in this training.

- **Other Possible Benefits** - An applicant for Medicaid must apply for any other benefits they might be eligible for.

- **Assets** - Asset limits are set for each program. Assets are determined as of the first moment of the month.

- **Income** - Income limits are based on either Poverty Level or Basic Maintenance Standards depending upon the program and the household size.

RESIDENT OF A HOUSEHOLD OR INSTITUTION?

One of the basic Medicaid eligibility criteria is where a person lives. Medicaid policy defines all dwellings as either a household or an institution. When determining Medicaid eligibility, it is important to decide if the place a person lives is a household or an institution.

	Household	*Institution
Definition	Any residence that does not meet the definition of an institution. Anyone who leaves or enters an institution in the same month they were residents of a household, is considered a resident of the household for that month.	To be an *institution, all of the following criteria must be met: ✓ it has an owner, manager, or other person in charge; ✓ it provides food, shelter and some treatment or service to its residents; ✓ it is designed to provide for four or more people who are not related to the owner or proprietor.
Eligibility	Eligible	Residents of certain *institutions are not eligible for Medicaid.

RESIDENTS OF *INSTITUTIONS

	ELIGIBLE	INELIGIBLE
***IMD**	☺ Under 21 or over 65 ☺ 21-22 if eligible & receiving Medicaid the month turn 21 ☺ Ages 22 - 65 when on *conditional or *convalescent leave	☹ Between the ages of 21-65 ☹ 21 year old discharged from IMD ☹ Leave IMD for medical treatment
***Correctional Facilities**	☺ If awaiting permanent placement	✔
***Medical Institutions**	✔	*Medical institutions primarily providing diagnosis, treatment or care to persons with TB.
Non-Medical *Private *Institutions	✔	
Non -Medical *Public *Institutions	☺ Primary purpose of getting an education or training ☺ Residents of *Community Residence Facilities	*Public, non-medical institutions

* *Definitions on next page*

INSTITUTIONAL DEFINITIONS

COMMUNITY RESIDENCE FACILITIES:

A facility serving less than 16 people that is primarily operated as a residence for the welfare of the people who live there. To be a community residence, a facility must provide food and shelter and must make available other services (i.e. Social Services, help with personal living activities, training in socialization and life skills, etc.) This does not include correctional or holding facilities, half-way houses, community residences designed to serve more than 16 people, community residences serving more than 16 people or community residences on the grounds, of or adjacent to, an ineligible institution.

CONDITIONAL LEAVE:

When a resident of an IMD is released from the institution on the condition that the resident receives outpatient treatment or another comparable condition and is placed on a conditional leave.

CONVALESCENT LEAVE:

When the resident of an IMD is sent home from the institution for a trial visit and placed on convalescent leave.

CORRECTIONAL FACILITIES:

Residents of correctional or holding facilities are considered residents of such facilities until they are unconditionally released, or until they are released on bail, probation or parole.

IMD: INSTITUTION FOR MENTAL DISEASE

A hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services.

INSTITUTION:

To be an institution, all of the following criteria must be met: (1) it has an owner, manager, or other person in charge; (2) it provides food, shelter, and some treatment or service to its residents; (3) it is designed to provide for 4 or more people who are not related to the owner OR it is providing for 4 or more people who are not related to the proprietor.

MEDICAL INSTITUTION:

A facility that is organized to provide medical care.

PRIVATE INSTITUTION:

All institutions that do not fit the definition of public.

PUBLIC INSTITUTION:

A public institution is one which is the responsibility of a governmental unit or one where a governmental unit exercises administrative control.

APPLICATION FOR OTHER POSSIBLE BENEFITS

As a condition of eligibility for Medicaid, applicants and recipients must take the necessary steps to obtain **ALL** benefits to which they are entitled, unless they can show good cause for not doing so.

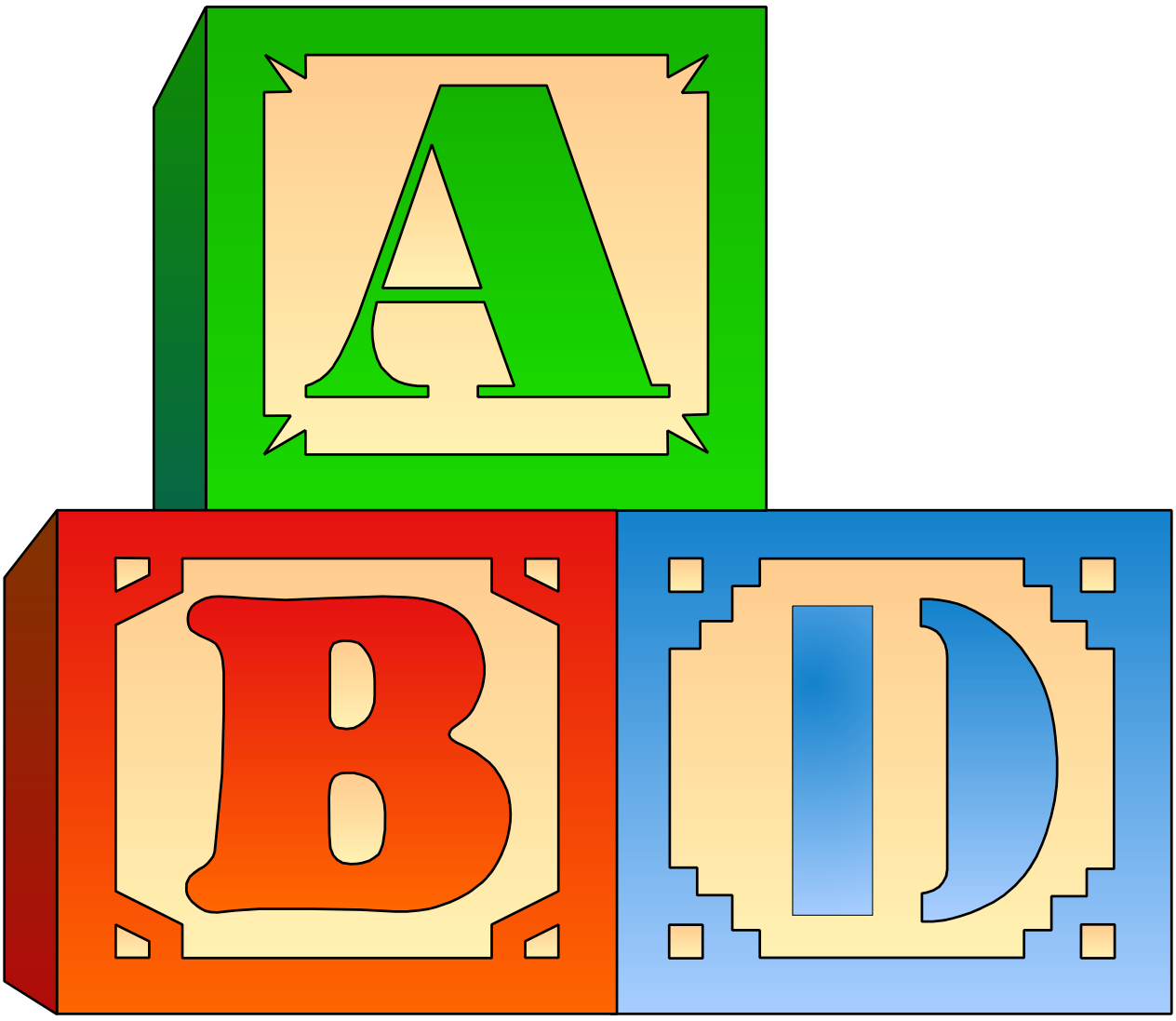
Benefits may include:

- Medicare
- Worker's Compensation Fund
- Veteran's Benefits
- Federal Retirement
- Social Security Retirement
- Survivors and Disability
- Railroad Retirement
- Unemployment Compensation, etc.

Not only are individuals required to apply for benefits but they also must follow through with any and all necessary eligibility requirements for those benefits.

For example: As a condition of eligibility, an individual who is entitled to receive Unemployment Compensation is required to apply for Unemployment Compensation and follow through with all necessary eligibility requirements, including the required job search activities.

Applicants and recipients ARE NOT required to apply for SSI benefits or Crime Victim Reparation payments.



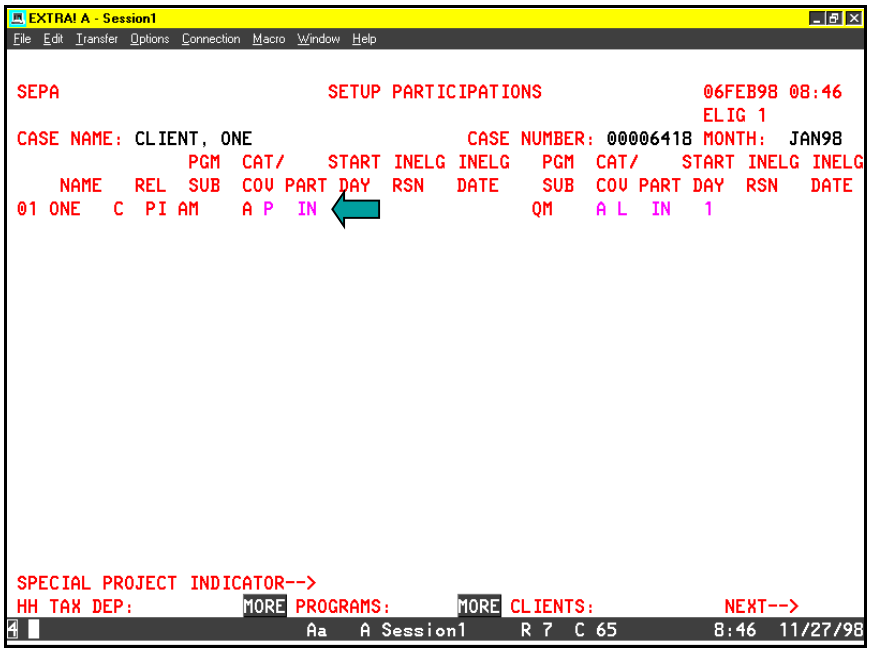
OVERVIEW

PACMIS Coding - SEPA

Participation Codes

For ABD you will only see the participation codes of:

- ☺ IN- for the aged or disabled person
- ☺ OU*- for children of a disabled adult or siblings of a disabled child and non household members
- ☺ DM- for spouses or parents of unemancipated children



- ☺ SS- for SSI recipients and other disabled individuals (see page 5)

Program and **Category Codes**

Category Codes require PACMIS to look for age or disability.

A Aged - over age 65
B Blind*
D Disabled*

*as determined by Social Security or Medical Review Board

Coverage Codes - tell PACMIS how to look at income or restrictions.

A	Disabled Adult Child
D	Physical Disabilities Waiver
E	Emergency Medical Only
H	Brain Injury Waiver
I	SSI Recipient (AUTO SET)
K	SSI Kids
L	SLMB Program
M	QI-1 Group
O	FM-OO
P	Pickle People (AUTO SET)
S	1619A / 1619B Client
T	Tech Dependent Waiver
W	Disabled / Early Widow(er)

Auto Set means that PACMIS puts the code on SEPA from other information that you entered. The 'I' comes from SSI income posted on UNIN. It does not remove the 'I' however, when SSI is removed. You must do that manually or the income will not count. The 'P' comes from the PIED screen if they pass the income calculation for

DEEMING RULES

- ✖ For A, B & D Medicaid, deeming rules are meant to insure that other household members have enough income to take care of their needs. *(The BMS for all eligible household members is meant to accomplish the same thing for Family Related Medicaid.)*

- ✖ Because of the rules for financial responsibility, deeming rules require deeming only from **spouse to spouse** and **parent to child**. *(**Deeming** from **child to parent** or **sibling to sibling** or **grandparent to child is not allowed**.)*

- ✖ For A, B & D Medicaid, there are only two BMS household sizes - a 1 person BMS or a 2 person BMS. A case for a disabled child has a BMS of one, even though his/her parents may be deemed. MWI cases will show HH size reflective of the number of people in the household.

- ✖ When an alien is sponsored by an individual, **do not** deem the income and assets of the sponsor, count only the amount given to the alien. Follow sponsor deeming rules.

- ✖ PACMIS can not do spousal and parental deeming on the same case. Set up separate cases for a disabled parent and a disabled child(ren). Set up separate PACMIS cases for each disabled child.

- ✖ PACMIS has been programmed to not deem income to or from a person who receives SSI. However, for spousal deeming, the spouse must be coded as 'DM' on SEPA for asset deeming. For parental deeming, do not deem parental income to a child if any parent in the home receives SSI. Code both parents 'SS' on SEPA.

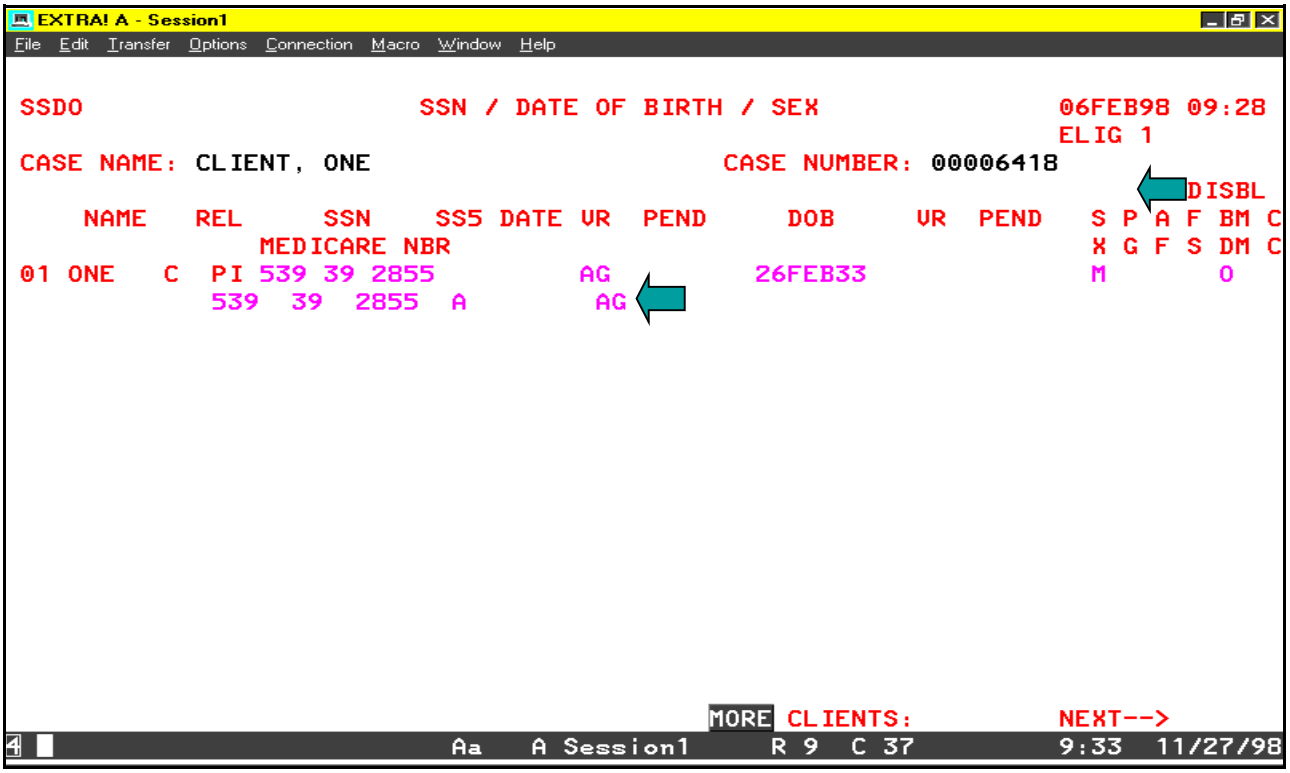
- ✖ PACMIS does not recognize the 'UB' participation code for ABD. Therefore, you cannot have a PN+ program and a DM program on the same case.

- ✖ Children age 18-21 can remain in the household if they are in school full-time. If an 18-21 year old is not in school full time, their relationship must be coded as 'OR' or they must be removed from the household. Even though they are coded 'OU' for participation, they still receive an allocation of the parent's income. This allocation should not take place unless they are in school full time.

- ✖ SS is the most misused participation code. It was established for SSI recipients and is still used for that purpose; however, it is also used for a disabled person on another disabled person's case whether they receive SSI or not. It is used for protected group recipients on another person's case. It is used for both parents if either one of them receive SSI.

Medicare Number

The Medicare claim # is entered on the line below the client's Social Security Number. If you are opening a QMB/SLMB/QI-1, this field is required. The verification code is "AV", which means Medicare Part A is verified.



Medicaid will pay the Part B premium, even if the Medicare supplements are not opened along with Medicaid. The Buy-In will take place for a Medicare recipient that is coded 'IN' on any Medicaid program for that month. This can cause a problem for the client because the Buy-In will begin when eligibility is determined and then stop after eligibility is closed. Once the Buy-In stops, Social Security will be behind in collecting payments and begin taking the payments out of the client's check in a lump sum. This may leave the client very little to live on.

Disability Codes

- ☺ M- Medical Review Board (make sure there is an alert on EWAL to complete a new review packet before the expiration date)
- ☺ O- Other (SSA)
- ☺ Y- Receiving SSI

AGED MEDICAID (AM) Section 302

WHAT ARE SENIORS WORTH ANYWAY?

Remember old folks are worth a fortune, with silver in their hair, gold in their teeth, stones in their kidneys, lead in their feet, and gas in their stomachs.

♬ Aged Medicaid is a program for those 65 years of age and over. Choose the Aged Medicaid program, even if the client is disabled or is eligible under another program (except possibly FM).

♬ Workers have 30 days from the date of application to determine eligibility.

♬ Aged Medicaid recipients are required by policy to apply for Medicare Part B.

♬ This program falls under Poverty Limit rules but does allow a spenddown if the income limit is exceeded. The spenddown is based on BMS rules.

♬ Assets: $2000 for 1 person Household, $3000 for 2 person Household.

♬ Earned Income Disregards: Disregard $65 and ½ the remaining earned income.

♬ Review Period - No longer than 1 year, depending upon fluctuation of income.

♬ Household size for A, B & D Medicaid can only be one or two. A disabled person's spouse is coded 'DM'. Children of a disabled parent are coded 'OU'. Siblings of a disabled child are coded 'OU'. Parents are deemed.

♬ PMV (unearned income in kind) must be considered.

♬ Face to face interviews are not required, even for food stamp recipients.

ESTATE RECOVERY

The state (through ORS) has the right to recover, from the recipients estate, all Medicaid funds expended on a recipient who is 55 and over if there is no surviving spouse, child under 21, or disabled/blind child in the household.

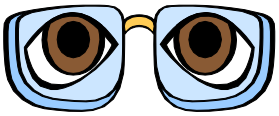
BLIND MEDICAID (BM) & DISABLED MEDICAID (DM)

Section 303

*Workers have 90 days to determine eligibility under these two programs.

BLIND MEDICAID (BM)

Blind Medicaid is a program for those who meet the criteria for blindness. Proof of blindness falls under the same criteria as proof of disability which includes:



- Social Security,
- SSI, or
- Medical Review Board decision.

If the blind individual has a disability other than blindness, open them “DM” instead of “BM”. Blind Medicaid does not fall under the poverty limit rules, you must use the BMS. Spenddowns are allowed for this program.

All Aged Medicaid rules apply to ‘BM’ except those specifically mentioned above.

DISABLED MEDICAID (DM)

A person must meet disability requirements to be eligible for the DM program.

Disability Criteria:

- Death- A person is always considered disabled in the month of death.
- SSI recipient (including when eligibility for SSI has been established and the payment has not yet been received).
- Proof of 1619B Status or other protected groups, (Vol. IIID Sec. 332).
- SS DI (SSA Disability) Recipient- If a client could be eligible for SSA, they must apply for it.
- Favorable decision from the Medical Review Board.

There is no age criteria for this program. Disability for children is based on the same criteria as adults.

This program falls under Poverty Limit rules but does allow a spenddown if the income limit is exceeded. The spenddown is based on BMS rules.

All Aged Medical rules apply to ‘DM’ except for those specifically mentioned above.

TIMELINESS OF ELIGIBILITY DETERMINATIONS
THE 90 DAY RULE Section 303-9

- You must approve or deny all disability-based Medicaid applications within 90 days. Any exception to the 90 day rule must be explained and justified in the case narrative.

- Do not allow a pending Medicaid decision of disability to go beyond 90 days unless it is in the client's best interest to keep it pending. A reason for an exception may be that you know a disability decision is immediately forthcoming.

- Applications for D Medicaid cannot be denied in 30 days simply because the client has failed to provide some other type of verification, such as assets.

- Set alerts for you to remind clients to provide requested verification if they have not done so within 30 days of the application date.

PCN VS. DISABILITY MEDICAID
THE 10 DAY RULE

Cowlishaw VS. Angus was a court order that provisioned we would comply with the following**:**

- (The 10 day Rule) - Explain the difference between PCN and DM and the procedure for establishing DM eligibility. If the client is not sure which program they want to pursue, give them 10 days to decide. Document the decision in the case narrative.

- If the client is eligible for PCN, send the appropriate PACMIS notice which informs him/her that a Medicaid Disability Determination can be requested if he/she believes they have a disability that would prevent work for at least 12 months.

- If the decision is to pursue Disability Medicaid and there is eligibility for PCN, open PCN pending the disability determination.

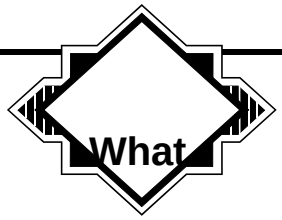
- Provide all applicants with the brochure " PCN and Medicaid for those with Disabilities. PM962"

STATE MEDICAID DISABILITY DETERMINATION

Vol IIID Section 303 pg 5-7

to submit a State Medicaid Disability Determination Request:

- The client has never applied for SSI and requests a determination of disability.
- The client has applied for SSI for the first time within a 12 month period and a decision has not been rendered.
    - Unless you have reason to believe otherwise, assume that the SSI/SSDI decision will not be made within the time we need to make an eligibility decision.
- The client was denied SSI more than 12 months ago.
- The client was denied SSI and or SSDI for a reason other than not being disabled.
- The client was denied SSI/SSDI within the last 12 months and claims a new disabling condition or an additional impairment that was not considered when Social Security made a final decision to deny disability.
- The client's SSI was stopped for a reason other than no longer being disabled, the client is not receiving SSDI benefits, the client is not in a protected group, and it has been nine months since SSI payments stopped.
- The client meets Medicaid's definition of a qualified alien, but his SSI ended because he does not meet at least one of the additional SSI alien provisions.
    - The Review Committee should re-determine eligibility within a year of the termination of SSI.
- The client's SSI or SSDI benefits are terminated because drug addiction or alcoholism was the determining factor for disability and there is a new disabling condition. It must be less than 12 months since the person's benefits were terminated.



to submit in a request:

- **Form 20 "Medical Disability Report" (if disability is of a physical nature) and/or Form 20M "Mental Status Report" (if disability is of a mental nature). If the Form 20 is not a possibility, obtain as much medical information as possible.**

  - **Forms must be completed and signed by a physician, psychiatrist, or licensed, certified psychologist.**
  - **Give the client a form MI706 for administrative payment of an examination. (MI706 is not sent to the Review Committee) Require recent medical information from the physician or psychologist who is actually treating the client.**
  - **Include any other reports or information (ie: recent hospital records, special test results, lab findings, etc.) if available. The MI706 will also cover the costs of copying medical information.**

  A Form 947 (Letter to providers) may be sent to the provider with the form 20. An MI-706 should also be sent to cover the costs.

- **Form 354 "Medicaid Disability Application"**
  - **All sections of the form must be complete and accurate. Incomplete or inaccurate information can affect the decision about disability.**
  - **Page 4 of the Form 354 should be completely filled out by the worker. It should include the worker's observations of the client's appearance and behavior.**

- **Form 121 "Report of Review Committee"**
  This is the cover sheet for the packet and should be completed with the client's information as well as the worker's name and phone number.

All items should be copied for the case file and the originals sent to Jack West at HCF. Any questions regarding the status of the disability should be referred to Alexandria Leffler.

It is the responsibility of the worker to assist the client in obtaining the required information for determining eligibility.

A Form 114 should be kept in the case file but not sent with the review packet.
****A Form 21 is NOT used for disability.**

DETERMINATION BY THE REVIEW COMMITTEE

If the request is denied:

- **Keep the PCN open or look for other Medicaid program eligibility.**
- **Deny or close the DM case "ND" and send the PACMIS denial/closure notice "MCND" or "MDND". In the notice give the specific reason for the denial, as it appears on the Form 121.**

If the request is approved:

- **Within 10 working days of being notified by the Review Committee, close the PCN case and open a DM case.**
- **The effective date of disability is the start date shown on the Form 121.**
- **Notify HCF of any retroactive DM coverage. Send this to:**

Nancy Thomson, Bureau of Eligibility Services

nancythomson@utah.gov

Phone 538-6714

LENGTH OF DISABILITY

- **If the form 121 says a disability review is "Not Indicated," no future review for disability is needed.**

- **When the Form 121 indicates a disability review is needed:**

    - **Do not close the case without allowing the client the opportunity to have the disability reviewed.**

    - **Do not count the retroactive period in deciding when to complete the next disability re-review.**

    - **Set an alert for 30 - 45 days before the disability end date to allow the client time to gather updated medical evidence for the review and for the Review Committee to render a decision.**

    - **Submit a new Form 354 (unless it is a 6 month review), a new Form 121 indicating "Continuing Disability Review", and updated evidence of disability.**

    - **Also submit the previous Form 354, the prior Form 121, and the prior evidence.**

- **If the new decision is to continue disability, keep the case open. Set an alert to control for future reviews.**

- **If the new decision indicates the client is no longer disabled, close the case. (Make sure to open any other program the client may qualify for.)**

1973 Criteria

Section 318

Two groups of individuals who were eligible in December 1973 based on the criteria in place at that time can remain eligible without having to meet certain current eligibility criteria.

Disability and Blindness in December 1973

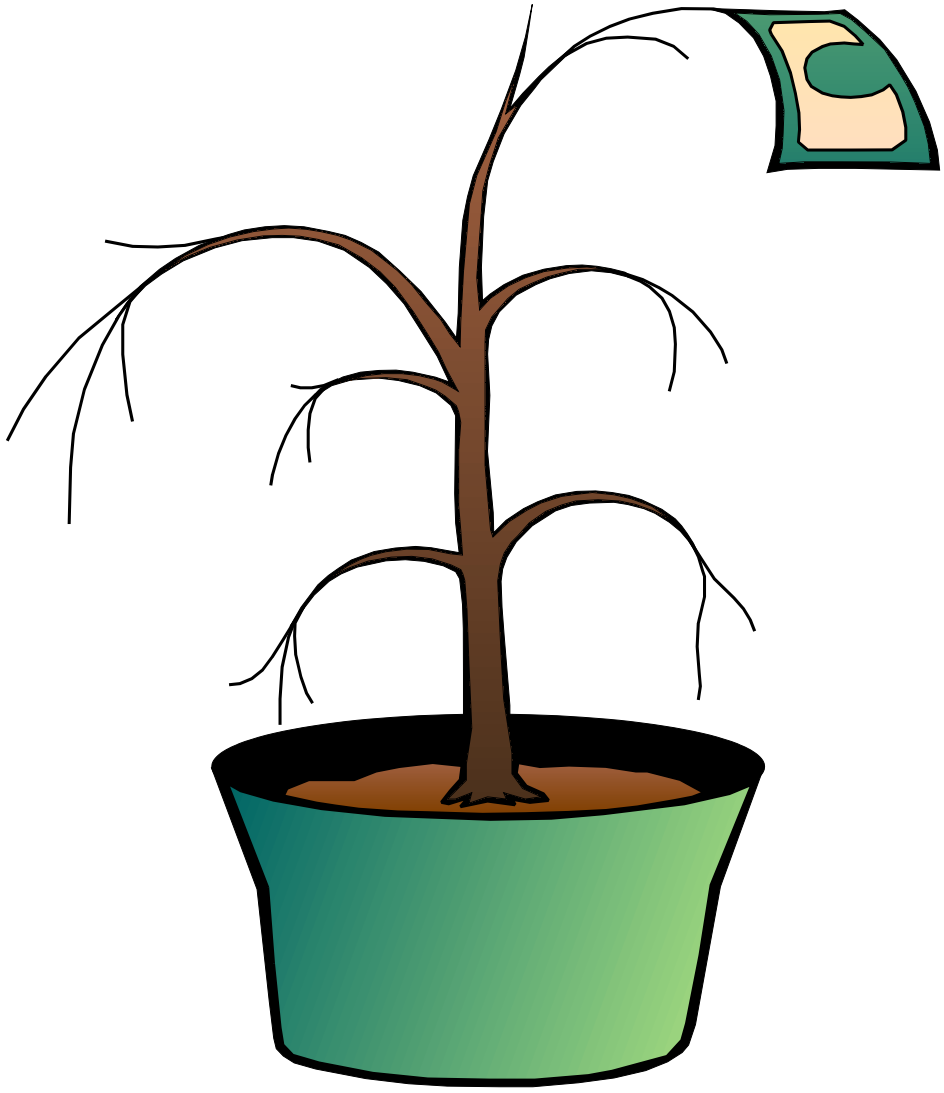
Any person who received Medical Assistance in December 1973 because of disability or blindness and whose case has not been closed since December 1973, will continue to be eligible for Medical Assistance as long as he meets the December 1973 criteria for disability or blindness and the current income and asset criteria. If the client is age 65 or older, open them under AM.

Eligible as a Spouse in December 1973

Any person who received Medical Assistance in December 1973 because of their spouse's disability or blindness will continue to be eligible for Medical Assistance as long as the spouse meets the December 1973 criteria for disability or blindness and the current income and assets criteria.

SOCIAL SECURITY INCOME

SSA and SSI



SSA

A person becomes eligible for Social Security by earning 'credits'. As people work and pay taxes they earn Social Security 'credits'. The amount of money needed to earn credits goes up every year. Most people need 40 credits (10 years of work) to qualify for benefits.

TYPES OF SSA BENEFITS

FULL RETIREMENT (SS RE)

If a person was born before 1938 they could be eligible for full Social Security at age 65. Beginning in the year 2003 the age at which full benefits are payable will increase in gradual steps from 65 to 67. This affects people born 1938 or after.

REDUCED BENEFITS (SS ER)

No matter what the full retirement age is, a person may start receiving benefits as early as age 62. If the benefits start early, they are reduced 5/9 of 1% for each month received before the full retirement age.

DIVORCE BENEFIT (SS OT)

If an individual has been divorced (even if they have remarried) they can receive benefits on their ex-spouse's record. In order to qualify, the individual must:

- **have been married to the ex-spouse for at least 10 years**
- **be at least 62 years old**
- **be currently unmarried**
- **not be eligible for an equal or higher benefit on another record**

If an individual receives off of the ex-spouse's record, it does not affect the amount of any benefits payable to the ex-spouse.

SURVIVOR'S BENEFITS (SS SU)

When a person dies, certain members of their family can be eligible for benefits off the deceased's record if the deceased had earned enough credits (5 year work history). The family members who can collect benefits include:

- **a widow(er) who is 60 or older, or 50 or older and disabled;**
- **a widow(er) at any age if caring for the deceased's child under age 16 or a disabled child who is receiving SSA;**
- **children**
  - **if they are unmarried, under age 18, or 19 and are still in secondary school as a full-time student, or**
  - **if they are severely disabled and the disability began before age 22.**
- **parents, if they were dependent upon the deceased for at least ½ their support.**

A special one time death benefit of $255 is made after a person's death and is payable to the widower or minor children.

BENEFITS TO DIVORCED WIDOWS OR WIDOWERS (SS WI)

If an individual divorced (even if they have remarried), the individual may be eligible for benefits off the deceased ex-spouse's record. The following must be true:

- **be at least 60 years old (or 50 years old if they are disabled) and have been married for at least 10 years;**
- **be any age if caring for a child who is eligible under the deceased's record;**
- **not be eligible for an equal or higher benefit on any other record**
- **not be currently married unless the remarriage occurred after age 60 (or age 50 if disabled).**

DISABILITY BENEFITS (SS DS)

A person may also receive benefits if they are disabled. To qualify for Social Security disability benefits a person must have worked long enough and recently enough under Social Security. A person can earn a maximum of up to 4 credits per year. Family members who qualify on someone else's work record do not need work credits. The number of credits a person needs depends on the age when they become disabled. Generally a person would need 20 credits earned in the last 10 years ending with the year they became disabled. Younger workers may qualify with fewer credits.

Who Can Receive Disability Benefits?

- **Widows(ers) with disabilities may be eligible on the record of a spouse.**
- **Children over age 18 with disabilities may be eligible for benefits on the record of a parent, if the disability started before age 22.**
- **If a person is receiving social security benefits, certain members of their families may also qualify for off the receivers record:**
  - **unmarried child under age 18 or**
  - **spouse who is 62 or older if he or she is caring for a child (under age 16) of the disabled person.**
- **If an individual should die, certain family members may qualify for disability benefits:**
  - **a disabled widow(er) 50 or older may receive if the disability began before the decedent's death or within 7 years of death.**

Things to remember:

- **Disability benefits do not begin until the sixth full month of disability. This is the waiting period.**
- **A person must provide original verification to apply.**
- **In a trial work period for 9 months (not necessarily consecutive) a person can work as much as they can without it affecting benefits. After a 3 month grace period the benefits will stop.**
- **More information is available on the Internet at: www.SSA.gov.**

SSI

SSI is Supplemental Security Income. Although this program is also administered by Social Security, the money to pay for benefits comes from general revenue funds of the U.S. Treasury. SSI makes monthly payments to people who have low incomes and few assets if the following are true.

They are:

- **living in the U.S. or the Northern Mariana Islands**
- **A U.S. citizen or be eligible under the new 'Alien Status' rules established in 1997**

and they must be:

- **65 or older, or**
- **blind, or**
- **disabled**

An SSI recipient that moves to Utah from another state must transfer their SSI record to Utah before they can become Utah residents.

Income and Assets

Income

How much money a person can have and still get SSI depends on whether or not they work and in which state they live. There is no state supplemental payment in Utah except for couples and singles who live with others. They may get a small supplement. See Table II and Table VII for amounts.

Assets

The asset limit for SSI eligibility is $2,000 in countable assets for one person or $3,000 for a couple. This is standard in the U.S.

Things to remember:

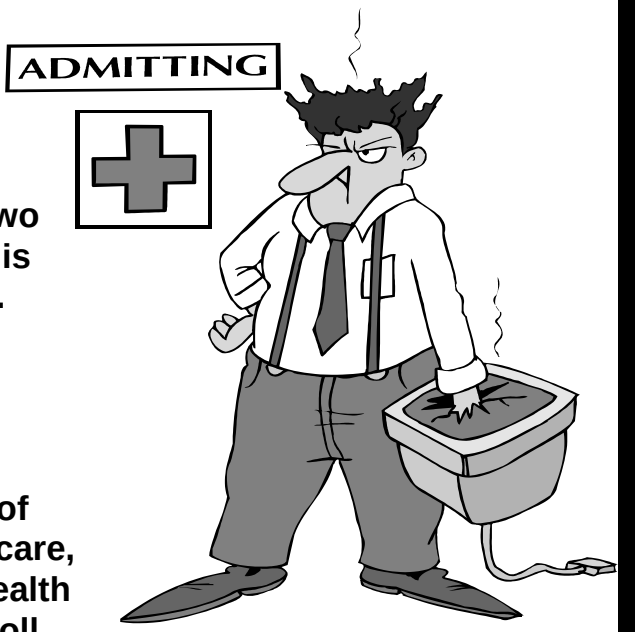
- **SSI income will fluctuate if there is other income being received or if the client is living in another household.**
- **Children as well as adults may receive SSI based on the same disability criteria.**
- **Medicaid, except for waiver or nursing home programs, disregards all income of SSI recipients.**

MEDICARE

A & B

MEDICARE & MEDI-GAP

Medicare is the federal health insurance program which is administered through the Social Security Office. It is for persons age 65 and over and certain disabled persons and persons with end stage renal disease. It has two parts. Part A is Hospital Insurance and Part B is Supplementary Medical Insurance (outpatient).



Medicare Part A

- **Part A Medicare pays some of the costs of hospitalization, certain related inpatient care, skilled nursing facility care, and home health services. It is financed primarily by payroll taxes based on covered work, both before and after becoming eligible for benefits. Benefits are provided automatically on the basis of past work.**

- **A person is eligible for benefits under Part A Medicare if they are age 65 or older and are eligible for any type of monthly Social Security benefit. If a person is disabled they may be eligible for Medicare if they have been entitled to disability benefits from Social Security for at least two years. A person may be eligible for Part B and not Part A.**

- **Hospital benefits begin when a person is admitted to a hospital. There is an initial deductible but no more than the actual charges. There are some other options available after the first 60* and 90** days. The deductible must be paid for each benefit period. The period ends 60 days after discharge from a hospital or nursing facility. If another hospital admission occurs, the person will have to pay an additional deductible as well as the co-insurance (cost sharing) amounts.**

Medicare Part B

Part B Medicare covers doctor's fees, most outpatient hospital services and certain related services. Part B is financed by monthly premiums from those who enroll in the program and by general revenues of the federal government. These benefits are available only if you pay the monthly premiums.

It is very important to encourage people to apply when they are eligible! About 95% of those eligible buy into Part B. Those that do not and later decide to buy in are charged penalties (10% per full year) back to the date they became eligible.

- **When a person enrolls in Part A Medicare, they also automatically enroll in Part B, unless a person refuses it. Even if a person is not eligible for premium-free Part A, a person can almost always enroll in Part B at age 65. A general enrollment period (January through March) is available for persons who did not elect to take Part B when they were eligible.**

- **A person must pay a monthly premium for Part B. If a person receives Social Security benefits, the premium is deducted from their benefits. Otherwise, the premium is billed by the government quarterly in advance. The premium is adjusted every January. If a person enrolls late or drops out and enrolls again their premium will be higher. The penalty is 10% more for each full 12 months that a person was eligible but did not participate.**

- **There is an annual deductible for Part B Insurance of the first $110 of the charges allowable by Medicare for covered medical services provided in a calendar year. Once the deductible is met, a person pays 20% of covered expenses.**

Medicare General Information

- **When It's Available**

Medicare becomes available at the beginning of the month in which a person becomes age 65, whether they are retired or working. It may also be available if a disability or chronic kidney disease which requires dialysis or a transplant is established. The disabled person is not entitled to monthly benefits because of their own disability for at least two years. Special provisions for chronic kidney patients allow entitlement at any age, but only for Part A. A person automatically applies for Medicare when they apply for Social Security benefits. When entitlement for Medicare occurs, the person will be asked if they wish to enroll in Part B or decline it.

❖ **Medicare Non-Coverable Items:**

- ♦ services not reasonable or medically necessary
- ♦ items for which a person is not legally obligated to pay
- ♦ services performed by a relative or household member
- ♦ services outside the U.S. (there are some exceptions)
- ♦ routine physical exams, eye exams, and glasses
- ♦ hearing aids
- ♦ dental services, except surgery due to fracture of bones
- ♦ routine foot care and orthopedics, except for diabetics
- ♦ custodial care
- ♦ cosmetic surgery, except after an accident
- ♦ most prescription drugs and immunizations
- ♦ acupuncture
- ♦ first three pints of blood for transfusions
- ♦ private nurses
- ♦ homemaker services, except under hospice provisions

❖ **Medi-Gap ~ Medicare Supplemental Insurance**

Medicare does not pay all of a person's medical expenses. There are deductibles, co-pays, non-allowable charges, and non-covered services. Most people need additional health insurance to fill the gaps in Medicare. These plans are called "Medi-Gap" policies. There are 10 standard plans and an option called Medicare Select.

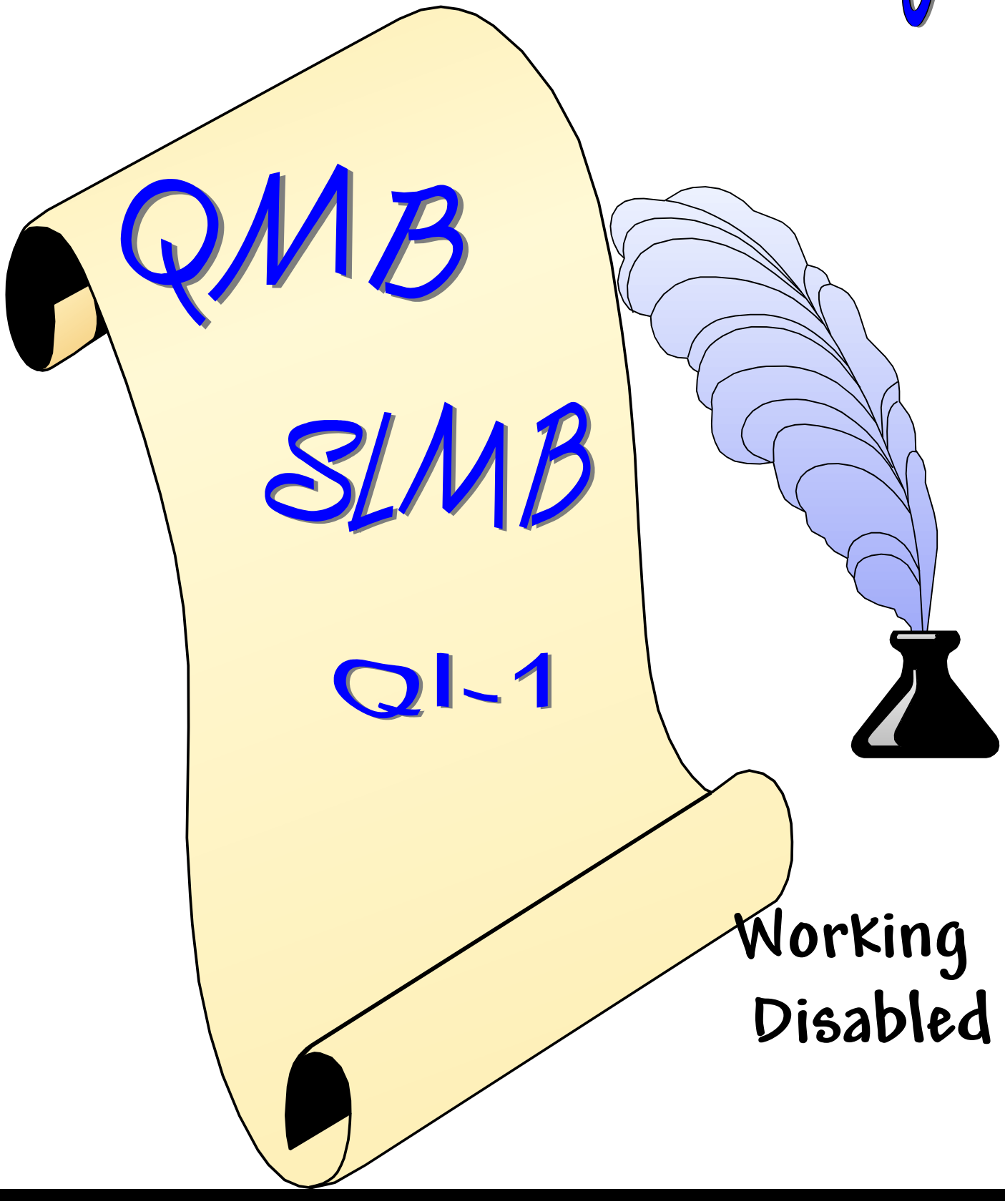
- ♦ **Medi-Gap policies are offered in various plans. A person does not need more than one Medi-Gap policy. Premiums and plans vary from one company to another and one area to another. All Medi-Gap policies are guaranteed renewable. They cannot discriminate because of health conditions. (See your Medicare 1999 book page 28 for a list of plan benefits.)**
- ♦ **Medicare Select is a Medi-Gap policy with a preferred provider agreement that has lower premiums if the participant agrees to use those providers for services.**

An Alternative--

In 1997 legislation created additional options to the original Medicare plan. These options are known as Medicare+Choice and are available in 1999. These plans include several types of managed care.

For general information regarding Medicare, call the Medicare hotline at 1-800-638-6833 or see www.medicare. gov.

Medicare Cost Sharing



Working Disabled

QUALIFIED MEDICARE BENEFICIARIES (QMB)

Volume III D, Section 371

Qualified Medicare Beneficiaries are people who:

1. **Meet the criteria for a Medicaid Program Type, and**
2. **Receive Part A Medicare or are eligible to receive it, and**
3. **Whose net income is equal to or less than 100%✳ of poverty, and**
4. **Who meet the asset criteria.**

Benefits: QMB will pay:

1. **Medicare Part B premiums.**
2. **Deductibles**
3. **20% co-payment of Medicare approved amounts, and the co-payment for Medicare approved skilled nursing home.**

Income (Limits change each April):

- **Income deductions are: $20 general income disregard and $65 and ½ of the remaining gross earned income.**
- **No spend down is allowed.**
- **Allowable deductions are the same as for A, B, or D Medicaid except health insurance and medical bills.**

Assets:

- **Asset limits are $4,000 for one person, $6,000 for two people.**

General Information:

- **Retroactive coverage is not allowed. Benefits begin the month following the month that eligibility is determined, (this includes the first month of Medicare Part A eligibility).**
- **It takes two or three months after becoming eligible for QMB for Medicaid to begin paying the Medicare premium.**
- **COLA increases do not affect an on-going recipient. PACMIS will automatically back out the COLA on the SSA income. Applicants must meet the poverty level limits at the time of application.**
- **QMB follows A,B, and D rules, unless otherwise stated.**
- **QMB is not a Medicaid, Medicare, or entitlement program; but, a Federal/State program. These funds replace those paid out by Medicaid for Medicare costs for the elderly and disabled who meet eligibility criteria.**
- **TPL is required.**

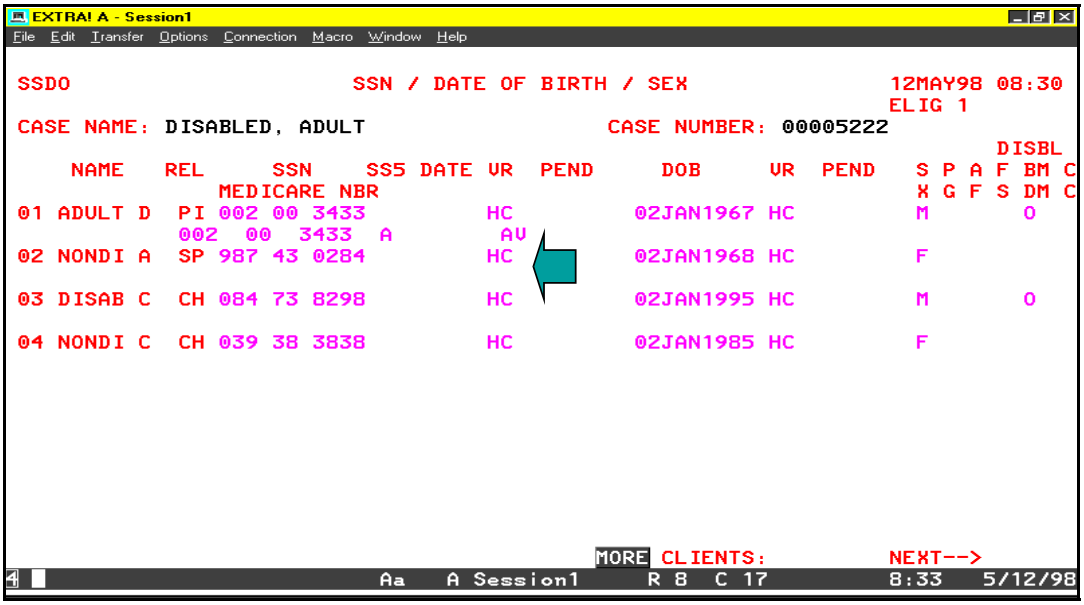
PACMIS Procedures for QMB

****Always determine eligibility for QMB as quickly as possible. QMB has no retroactive coverage and eligibility begins the month after the month eligibility has been determined.**

- **If you have a QM case with another program type, first register and determine eligibility for the other program type. After eligibility has been determined, go to APMA and add QM to the open case for the month following the month eligibility was determined.**

  Example: ***26 Jan 98 Application date***
  05 Feb 98 Verifications returned and eligibility determined
  01 Jan 98 Date of Entitlement for Medicaid (without retro)
  01 Mar 98 Date of Entitlement for QMB

- **Register with:**
  - **Program type - QM**
  - **Category code - Follows the Medicaid Program Type (AM, BM, DM)**
  - **Coverage group - blank**
- **SEPA - Code the Medicare A person 'IN'. Spouse may be coded 'IN' or 'DM'. Any children are coded 'OU'.**
- **SSDO - Social Security Number must be entered. The Medicare Number must also be listed underneath the SS# with the verification code 'AV' (Part A Verified). If disabled, the disability code must be entered.**



- **Whenever possible, open QMB along with a Medicaid program. The federal match restores Medicaid dollars paid out for the Medicare Part B.**
- **Always explain the QMB benefits to the client. The Buy-In takes 90 - 120 days to complete before they will see a change or get a refund.**

SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLMB)

Volume III D, Section 372

Specified Low-Income Medicare Beneficiaries are people who:

1. **Meet the criteria for a Medicaid Program Type, and**
2. **Receive Part A Medicare or are eligible to receive it, and**
3. **Whose net income is equal to or less than 120%✳ of poverty, and**
4. **Who meet the asset criteria.**

Benefits:

- **SLMB is not a Medicaid program but a program which pays for Part B of the client's MEDICARE premium. Part B Medicare covers a person's physician care, a variety of out-patient services, including out-patient hospitalization.**

The only benefit on this program is the payment of the Part B premium.

Income: (Limits change in April of each year)

- **No spend down is allowed.**

Assets:

- **Asset limits are $4,000 for one person, $6,000 for two people.**

General Information:

- **Applicants must pass all the QMB rules, except income.**
- **90 day retroactive coverage is allowed, but cannot begin before Medicare Part A eligibility begins.**
- **It takes two or three months after becoming eligible for SLMB for Medicaid to begin paying the Medicare premium. The client will be reimbursed by Social Security at that time, for each month of eligibility.**
- **SLMB on PACMIS is identified by an 'L' in the coverage code. The program will be QMB and the category code will match the A, B, or D category.**
- **COLA increases are treated the same as for QMB.**
- **TPL is not required.**

PACMIS Procedures for SLMB

- **Register the application for 'QM' with no coverage group code unless you know that the applicant will be over the QMB limit. Do not make the effective date retroactive. If the case fails QMB you can go back and change the effective date to include any retroactive period for which the client may be eligible. If the case fails QMB income, the QMIE screen will display the message "Try SLMB-Enter 'L' in Med Coverage Group on SEPA'. The QMIE screen will show income limits for QMB and SLMB. Use PF9 to exit.**

- **Return to APMA to change the effective date to include any retroactive months. Enter an 'L' in the Med Coverage Group. You will get a warning about registering a retroactive QM program.**

- **If you know the client will be over the QMB limit, you can enter the coverage group 'L' when you register the application. Set the effective date to include the retroactive months as requested and eligible.**

- **You must pass through the SSDO screen to verify Medicare coverage. Only clients who are Medicare eligible should have a number in the Medicare block.**

- **The Issuance Indicator will show 'HO' for hold and a hold reminder date will appear. This is because PACMIS will not issue a medical card for SLMB.**

- **If you register someone for SLMB and find they are eligible for QMB, you will need to deny the SLMB because the effective date will be different. The QMB must not be approved until the month after the month eligibility is determined.**

- **Applicants may fail QMB income limits for January through March, (because the COLA increases in January and the poverty level does not increase until April). However, they may be eligible for SLMB during those months. When the poverty level income limit changes occur in April, they may be then eligible for QMB. You will need to set an alert to control for this.**

- **You cannot open SLMB in a month where a client was eligible for QMB.**

Qualifying Individuals QI-1

Volume III D, Section 373

Qualifying Individuals are people who:

1. **Are receiving Part A Medicare, or are eligible to receive it, and**
2. **Whose net income is 120% to 134% of poverty for Group 1 or 135% to 175% of poverty for Group 2, and**
3. **Who meet the asset criteria, and**
4. **Who are not receiving Medicaid.**

Benefits:

They will receive assistance with the Part B Medicare premium only.

QI or Medicaid?

If the client qualifies for Medicaid, the client cannot receive QI benefits.

A person who qualifies for both Medicaid and QI will have a spend down on their Medicaid case. QI can only be opened if the client decides to not pay the Medicaid spend down.

If the case is open QI-1 and the client wants Medicaid for a month of spend down, the client must submit a new application. Remember to close the QI case if Medicaid is opened.

General QI Information:

- **No spenddown is allowed.**
- **There are no TPL requirements for QI-1.**
- **QI-1 allow for a 3 month retroactive period. However, benefits cannot begin prior to January 1, 1998.**
- **COLA adjustments will be handled just as with QMB and SLMB.**

- **QI is not an entitlement program. There is no guarantee that every eligible person who applies for the Qualifying Individuals program will receive the benefits for the calendar year.**

  The budget for this program is funded each calendar year, so the program may be stopped any time during the year based on availability of funds.

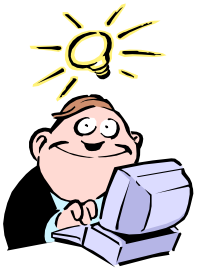
  However, even if funding is stopped for the year, a person who is currently receiving QI benefits will continue to receive benefits for the rest of the year. There is no guarantee that he will receive the QI benefits for the following year.

  Priority of coverage in subsequent years will be given to individuals who were receiving QMB, SLMB or QI benefits in December of the previous year.

  Even if funding is stopped for the year, we must still accept and process QI applications, and send appropriate denial notices.

Pacmis Procedures For QI

QI-1 Program type: **QM**
Coverage Group: **M**



1. **Register the case QM with no coverage group (unless you know the client is over the QMB limit).**

2. **Determine eligibility as you would for QMB. You must go through SSDO to verify Medicare coverage. Enter the client's Medicare number.**

3. **QMIE: If the case fails the income limit on QMB and SLMB, there will be the following message:**
   "Change Coverage Group to M on SEPA"
   PF9 to exit screen

4. **At APMA:**
   - ❑ **Change the effective date if needed (remember to look at eligibility for retroactive coverage).**
   - ❑ **At the Med Cov field: Enter an "M". (There will be a number of warnings about registering a retroactive case for QM.)**

5. **Process eligibility screens. (You may have to re-enter data if you have changed the effective date.)**

6. **QMIE**
   - ❑ **Shows eligible.**
   - ❑ **Issuance indicator will show 'HO' because there is no medical cards for QI.**
   - ❑ **Authorize and send notices.**

Application for QMB, SLMB, or QI

Section 375-2

Use the same application for QMB, SLMB, and QI that is used to apply for Medicaid.

If the client is currently open for Medicaid, a new application is not needed.

If a client is receiving QMB or SLMB only, and would like to add Medicaid, a new application is needed.

If QI is the only program open and a client wants to apply for a month of Medicaid with a spenddown, the client needs to submit a new application. If a client wants Medicaid ongoing, the QI must be closed.

Effective Dates of Coverage

Section 611-2, 375-5

Eligibility cannot begin before the Medicare eligibility begins.

QMB
The effective date of QMB benefits is the first day of the *month AFTER the month eligibility* has been determined or the month after initial Part A eligibility.

SLMB
The effective date of SLMB benefits is the first day of the month of application, or on the first day of any month of the retroactive period that the client meets the eligibility criteria.

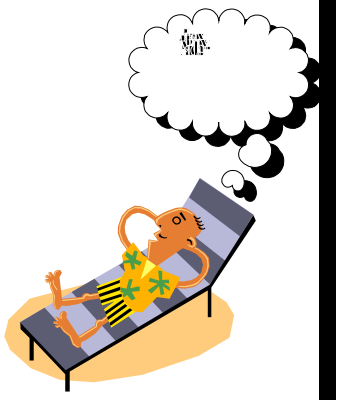
QI 1
The effective date of QI benefits is the first day of the month of application, or on the first day of any month of the retroactive period that the client meets the eligibility criteria. Eligibility cannot begin before January 1, 1998.

For QI, the clients cannot be receiving Medicaid. If the client is eligible for both types of assistance, ask the client if they want to meet the spenddown on a monthly basis. If so, do not open the QI program.

COLA Increases

Section 375-5

RECIPIENTS:



During the first 3 months of the calendar year do not close a QMB case if the cost of living increases for SSA, Railroad Retirement, and Black Lung, causes the recipient's income to be over the QMB limit.

When the federal poverty limit is adjusted (usually in April), look at these cases to see if the client qualifies using the new poverty limit.

If eligible for QMB:

PACMIS will automatically back out the SSA COLAs for poverty level programs. Workers will have to manually back out Railroad Retirement and Black Lung to see if the COLA increase has caused the case to become ineligible.

When the new poverty limits are instituted in April PACMIS will automatically add the COLA to SSA. Workers will have to manually add the Railroad Retirement and Black Lung COLAs to determine eligibility with the new poverty limits.

NEW APPLICANTS IN JANUARY - MARCH:

When determining eligibility for new applicants:

1. **Use their current income (including any cost of living increase).**

2. **Compare their income to the current available 100% of Poverty Limit. (This income limit will be before the adjustment in April).**

3. **If the new applicant's income is over the 100% of the Poverty Limit, the person is not eligible for QMB. Look at eligibility for the SLMB program.**

4. **In April, when the Poverty Limit is adjusted, the client whose QMB application was denied may now be eligible for QMB because of the new income limit.**

    - **Workers will receive an alert telling them that the client may now be eligible for QMB. Determine eligibility for QMB. If eligible for QMB, close the SLMB and open the QMB case for the month after eligibility has been determined.**

WORKING DISABLED

Volume IIID, Section 379

- **The Working Disabled are disabled people eligible for Part A Medicare AND not eligible for Medicaid without a spenddown. They used to receive SSA disability payments, but are now ineligible because they earn too much money.**

- **Clients must be eligible for Medicare Part A under Section 1818A of the Social Security Act.**

- **The Working Disabled are eligible ONLY for payment of the Part A Medicare premium.**

- **Assets limit is $4,000, if the client is not married or is separated from a spouse. If the client is married and not separated, the asset limit is $6,000.**

- **Countable income must be less than or equal to 200% of the Federal poverty level (Table VII.) To decide if you should compare income to the poverty limit for a 1 person household or a 2-person household, follow the rules in Section 475-2.**

- **You cannot open a Working Disabled case in the PACMIS system. If a client is eligible, you must contact the ORS Buy-In specialist to make sure the client is accreted to the Part A Medicare Buy-In. Special Procedures:**

  1. When an applicant requests assistance, first verify that the individual is not eligible for Medicaid benefits.

     - **Use PACMIS to determine the countable income, then compare the countable income to the poverty figure for the number in the household corresponding to the number in the BMS used by PACMIS.**
     - **Record the application in PACMIS as you would an application for D Medicaid and QMB.**

     - **Enter all necessary information as you would for a Medicaid application.**

- **PACMIS will verify that the client is not eligible for Medicaid and will do the income calculation, determining the countable income for the case so you can compare the countable income to 200% of poverty.**

- **PACMIS will also tell you the correct number in the household, using the spousal deeming rules to decide if the spouse should be included in the BMS.**

2. **Send a Notice. Be sure the approval or denial notice includes the correct policy citation. (You may want to use PACMIS for this, since you need to deny the DM and QMB applications you registered. Use a free-form notice to tell the client about the approval or denial of the Working Disabled Medical assistance.)**

3. **If the client is approved, contact the ORS Buy-In specialist. He will make sure that the client's Part A Medicare premium is paid.**

4. **If a recipient becomes ineligible, contact the ORS Buy-In Specialist so the Part A Medicare premium will no longer be paid.**

5. **Control for Income Changes. If the client has fluctuating income, average according to prospective budgeting rules. Use a tickler file or other manual device to make sure that income changes are reported.**

6. **These cases must be reviewed at least once every 12 months. ORS will notify you at review time.**

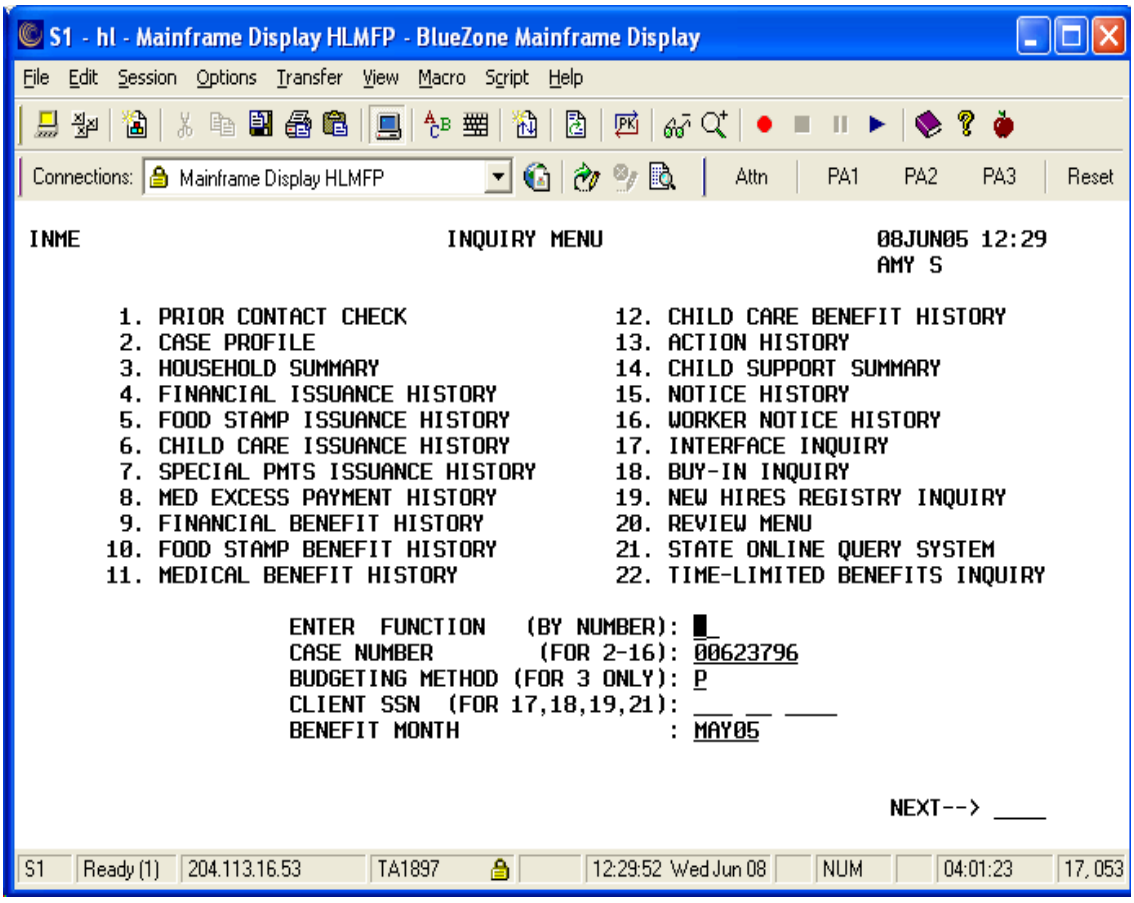
How To Determine Part A Eligibility

To find out if the client is receiving Part A and/or Part B Medicare, use our interface screens.

Go to INME:

Function #17

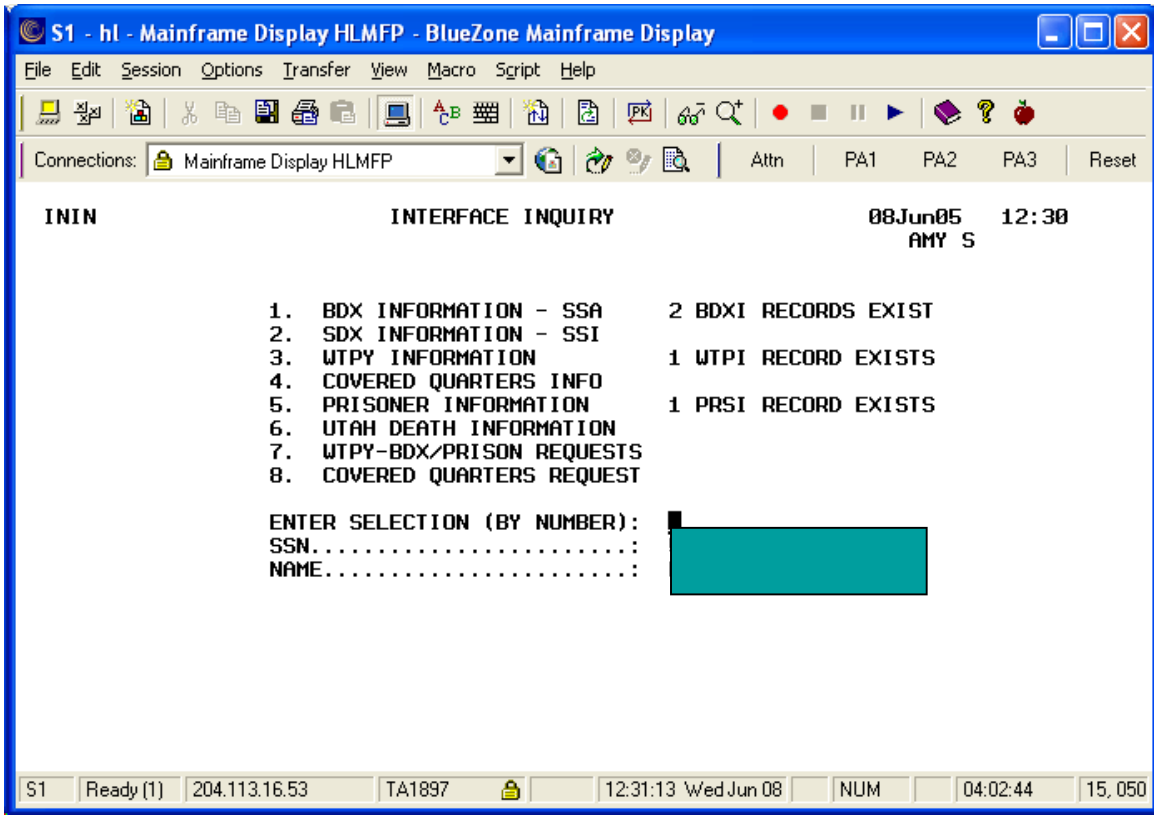
Enter the client's social security number.



At the ININ screen, your options are:

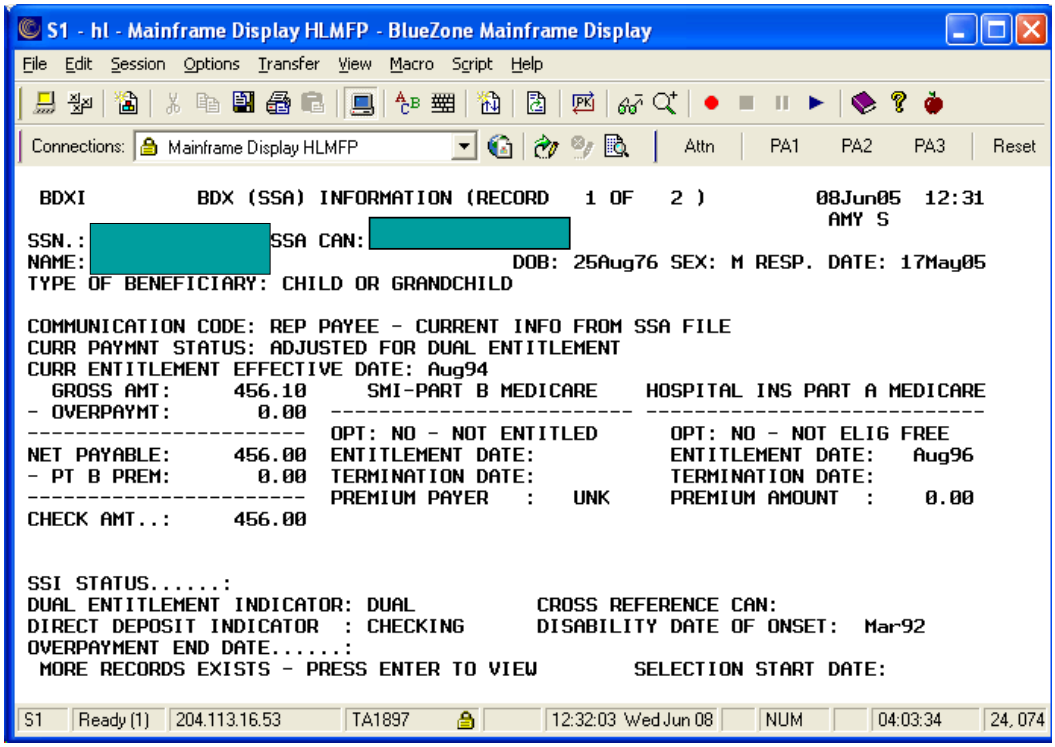
#1 BDX Information
Shows SSA information
#2 SDX Information
Shows SSI information
#3 WTPY Information
Shows general SSA/SSI information
#4 Covered Quarters Info
#5 WTPY Manual Requests
Used to generate a manual SSA/SSI interface
#6 Covered Quarters Request

Select Function #1 "BDX Information"



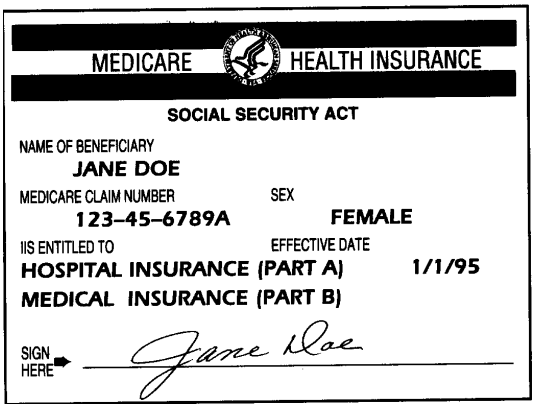
- **The BDXI information is the Social Security (not SSI) information. It also shows eligibility for Part A and B Medicare.**

- The Medicare 'Date of Entitlement' is usually 2 years from the 'Current Entitlement Effective Date' for disabled people.



Another way to determine if a client is receiving PartA or Part B Medicare is to ask the client to bring in their Medicare card.

Here is a copy of a Medicare Card:



Jun 2005

Comparison Chart of QMB, SLMB, QI-1 Programs

	QMB	SLMB	QI-1
Program Type	QM	QM, Coverage Code "L"	QM, Coverage Code "M"
Eligibility Criteria	Must receive Part A Medicare	Must receive Part A Medicare	Must receive Part A Medicare Must not receive Medicaid
Program Benefits	1. Pays Part B premium 2. Pays Part B Medicare deductible 3. Pays co-payment for Part B Medicare covered services 4. Pays Part A hospital deductible 5. Pays the daily coinsurance charges for extended hospital and skilled nursing facility stays	1. Pays monthly Part B premium	1. Pays monthly Part B premium
Income Limits Change Every April	Must be under 100% of Poverty	Must be over 100% of Poverty AND under 120% of Poverty	Must be over 120% of Poverty AND under 135% of Poverty
Income Deductions	1. $20 General Exclusion 2. $65 and ½ from earned income 3. Impairment related work expenses	Same as QMB	Same as QMB
Asset Limit	1 person $4000 2 people $6000	Same as QMB	Same as QMB
Payment of Part B Premium	Paid through Buy In	Paid through Buy In	Paid through Buy In
Medicaid Coverage	Can receive QMB and Medicaid	Can receive SLMB and Medicaid	Cannot receive QI-1 while receiving Medicaid

	QMB	SLMB	QI-1
TPL Requirements	**Required**	**Not required**	**Not required**
Effective Date of Coverage	**Coverage begins the month after eligibility has been determined**	**First of month that eligibility has been determined**	**First of month that eligibility has been determined**
Retroactive Coverage	**Not allowed**	**Three month retroactive period**	**Three month retroactive period, but not before January 1, 1998**
Spend Down	**Not allowed**	**Not allowed**	**Not allowed**
Medical Card	**Issued (card color is Peach)**	**None issued**	**None issued**
Entitlement	**Is an entitlement program**	**Is an entitlement program**	**Is not an entitlement program**